CHAPTER 500

CARE COORDINATION REQUIREMENTS

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500 CHAPTER OVERVIEW

This Chapter addresses policies for coordination of AHCCCS covered health care services provided to AHCCCS members through Contractors and fee-for-service providers. Care coordination requirements include the following:

1. Primary care provider (PCP) roles, responsibilities, selection and assignment

2. Transition between Contractors, services and programs

3. Member records and release of information protocol.

Note that AHCCCS requires Arizona Long Term Care System (ALTCS) members to have both a PCP for acute care services and a case manager for long term care services. Refer to Chapter 1600 for ALTCS care coordination requirements and case manager responsibilities.

Refer to Chapter 600 for information regarding specific AHCCCS requirements for participating providers.

Refer to the AHCCCS Contractor Operations policies for more information regarding acute and ALTCS member transition policies:

- Change of Plan policy

- Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes policy

- ALTCS Enrollment Choice in a Choice County and Change of Program Contractor policy

- **DEFINITIONS**

For the purpose of this Chapter, the following definition applies:

"Day" means a calendar day, unless otherwise specified.

- **REFERENCES**

1. Title 42 of the Code of Federal Regulations (42 CFR) 422.113 (Special Rules for Ambulance Services, Emergency and Urgently Needed Services, and Maintenance and Post-Stabilization Services)
2. 42 CFR 438.114 (Emergency and Post-Stabilization Services)
3. 42 CFR 438.200 *et seq* (Quality Assessment and Performance Improvement Including Health Information Systems)
4. 42 CFR 431.300 *et seq* (Safeguarding Information on Applicants and Recipients)
5. 45 CFR, Parts 160 and 164 (HIPAA Privacy Requirements)
6. Arizona Revised Statutes (A.R.S.), Title 36, Chapter 29, Articles 1, 2 and 4
7. A.R.S. § 36-261*et seq* (Children's Rehabilitative Services)
8. Title 9 of the Arizona Administrative Code (9 A.A.C.), Chapters 22, 28 and 31, Article 2 (Scope of Service)
9. 9 A.A.C. 22, 28 and 31, Article 5 (General Provisions and Standards)
10. 9 A.A.C. 31, Article 16 (Services for Native Americans)
11. AHCCCS Contracts

510 PRIMARY CARE PROVIDERS (PCPS)

- **PCP ROLE AND RESPONSIBILITIES**

  The primary role and responsibilities of primary care providers participating in AHCCCS programs include, but are not be limited to:

  1. Providing initial and primary care services to assigned members

  2. Initiating, supervising, and coordinating referrals for specialty care and inpatient services and maintaining continuity of member care

  3. Maintaining the member's medical record.

- **PROVISION OF INITIAL AND PRIMARY CARE SERVICES**

  Contractors are encouraged to ensure the provision of an initial health screening/examination to members upon assignment to a PCP in order to determine health status and to obtain baseline information. The PCP is responsible for rendering, or ensuring the provision of, appropriate preventive and primary care services to the member. These services will include, at a minimum, the treatment of routine illness, maternity services if applicable, immunizations, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for eligible members under age 21, adult health screening services (including well woman services), and medically necessary treatments for conditions identified in an EPSDT or adult health screening. Each EPSDT member must receive health screening/examination services as specified in Chapter 400.

- **PCP CARE COORDINATION RESPONSIBILITIES**

PCPs in their care coordination role serve as the referral agent for specialty and referral treatments and services provided to AHCCCS members assigned to them, and attempt to ensure coordinated quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

1. Referring members to providers or hospitals within the Contractor network, as appropriate, and if necessary, referring members to out-of-network specialty providers

2. Coordinating with the Contractor in prior authorization procedures for members

3. Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned members by other providers, specialty providers and/or hospitals

4. Coordinating the medical care of the AHCCCS members assigned to them, including at a minimum:

    a. Oversight of drug regimens to prevent negative interactive effects

    b. Follow-up for all emergency services

    c. Coordination of inpatient care

    d. Coordination of services provided on a referral basis, and

    e. Assurance that care rendered by specialty providers is appropriate and consistent with each member's health care needs.

- **MAINTENANCE OF THE MEMBER'S MEDICAL RECORD**

  Refer to Chapter 900, Policy 940 (Medical Records and Communication of Clinical Information), for information regarding the maintenance of the member's medical record.

- **PCP ASSIGNMENT AND APPOINTMENT STANDARDS**

  Contractors must make provisions to ensure that newly enrolled members are assigned to a PCP and notified after the assignment within ten (10) calendar days of the enrollment notification. Contractors must ensure that PCPs under contract with them register with AHCCCS Administration as an approved service provider and receive an AHCCCS provider ID number. AHCCCS allows licensed providers from several medical disciplines to qualify as PCPs. These medical disciplines include physicians and certified nurse practitioners in the specialty areas of general practice, family practice, pediatrics, internal medicine and obstetrics and gynecology. In addition, physician assistants under physician supervision may serve as PCPs. There may be circumstances when the specialist is the PCP (e.g., a member is designated with special health care needs).

  Refer to Chapter 600, Provider Qualifications and Provider Requirements, for information regarding specific AHCCCS requirements for participating providers.

  Contractors are required to keep a current file of member PCP assignments. It is critical that each Contractor maintains accurate tracking of PCP assignments in order to facilitate continuity of care, control utilization and obtain encounter data.

The Contractors will allow the member freedom of choice of the PCPs available within their network. If the member does not select a PCP, the member will be automatically assigned to a PCP by the Contractor. Contractors must ensure that their network of PCPs is sufficient to provide members with available and accessible service within the following time frames:

1. Emergency services - within same day

2. Urgent care services - within two days, and

3. Routine care services - within 21 days.

Contractors must develop procedures to ensure that newly enrolled pregnant members are assigned to a PCP who provides obstetrical care or are referred to an obstetrician, in accordance with AHCCCS policy regarding maternity care. (Refer to Chapter 400, Policy 410.) Women may elect to use a specialist in obstetrics and/or gynecology for well woman services.

- **PHYSICIAN EXTENDER VISITS IN A NURSING FACILITY (NF)**

Both initial and any or all subsequent visits to an AHCCCS-enrolled member in a NF or skilled nursing facility (SNF), made by a physician extender, are covered services when the following criteria are met:

1. The physician extender is working in collaboration with a physician

2. The physician extender is not an employee of the facility, and

3. The source of payment for the SNF/NF stay is Medicaid.

For the purposes of this policy, physician extenders are defined specifically as nurse practitioners and physician assistants working within the scope of their practice.

- **MEDICAL RESIDENT VISITS UNDER SPECIFIC CIRCUMSTANCES**

Under specific criteria, medical residents may provide low level evaluation and management services to members in designated settings without the presence of the teaching physician.

Refer to the AHCCCS Contractor Operations Policies, Policy 204 - Teaching Physician Reimbursement Option, for a complete discussion of this option.

- **REFERRALS AND APPOINTMENT STANDARDS FOR SPECIALTY CARE**

Contractors must have adequate referral procedures in place in order to insure appropriate availability and monitoring of health care services. Referral procedures must include the following:

1. Utilization of a Contractor specific referral form

2. Definition of who is responsible for writing referrals, authorizing referrals, and adjudicating disputes regarding approval of a referral (referral to either a contracting or non-contracting provider), and

3. Specifications addressing the timely availability of specialty referral appointments:

   Specialty Appointments

   a. Emergency appointments – within 24 hours of referral

   b. Urgent care appointments – within three (3) days of referral, and

   c. Routine care appointments – within 45 days of referral (unless specific circumstances justify a delay).

Dental Appointments

a. Emergency appointments - within 24 hours of request

b. Urgent appointments - within three (3) days of request, and

c. Routine appointments - within 45 days of request.

Maternity Care Appointments

a. First Trimester appointment - within 14 days of request

b. Second Trimester appointments - within seven (7) days of request, and

c. Third Trimester appointments - within three (3) days of request

d. High Risk Pregnancies - appointment within three days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists.

4. Specifications regarding Contractor staff responsible for:

   a. Monitoring member compliance with referral appointments

   b. Monitoring primary care provider receipt of specialist/consulting reports

   c. Monitoring Early and Periodic Screening, Diagnosis and Treatment related referrals

   d. Monitoring behavioral health referrals.

5. Specifications and procedures for linking specialty and other referrals to the financial management system; such as through the prior authorization process.

   Refer to Chapter 400 for family planning services information.

520 MEMBER TRANSITIONS

Contractors must identify and facilitate coordination of care for all AHCCCS members during changes or transitions between Contractors, as well as changes in service areas, subcontractors, and/or health care providers. Members with special circumstances (such as those listed below) may require additional or distinctive assistance during a period of transition. Policies or protocols must be developed to address these situations. Special circumstances include members designated as having "special health care needs" under Policy 540 of this Chapter, as well as members who have:

1. Medical conditions or circumstances such as:

    a. Pregnancy (especially women who are high risk and in third trimester, or are within 30 days of their anticipated delivery date)

    b. Major organ or tissue transplantation services which are in process

    c. Chronic illness, which has placed the member in a high-risk category and/or resulted in hospitalization or placement in nursing, or other, facilities, and/or

    d. Significant medical conditions,(e.g., diabetes, hypertension, pain control or orthopedics) that require ongoing care of specialist appointments.

2. Members who are in treatment such as:

    a. Chemotherapy and/or radiation therapy, or

    b. Dialysis.

3. Members with ongoing needs such as:

    a. Durable medical equipment including ventilators and other respiratory assistance equipment

    b. Home health services

    c. Medically necessary transportation on a scheduled basis

    d. Prescription medications, and/or

    e. Other services not indicated in the State Plan, but covered by Title XIX for Early and Periodic Screening, Diagnosis and Treatment eligible members.

4. Members who at the time of their transition have received prior authorization or approval for:

    a. Scheduled elective surgery(ies)

    b. Procedures and/or therapies to be provided on dates after their transition, including post-surgical follow-up visits

    c. Sterilization and have a signed sterilization consent form, but are waiting for expiration of the thirty-day period

    d. Appointments with a specialist located out of the Contractor service area, and

    e. Nursing facility admission.

NOTIFICATIONS REQUIRED OF CONTRACTORS

1. Relinquishing Contractors must provide relevant information regarding members who transition to a receiving Contractor. The Enrollment Transition Information (ETI) form must be transmitted for at least those members with special circumstances, listed in this policy, who are transitioning enrollment to another Contractor. There are three specific ETI forms:

   a. Exhibit 520-1 is used by the acute care Contractors.

   b. Exhibit 520-2 is used by the Arizona Department of Health Services, Children's Rehabilitative Services (ADHS/CRS), when transitioning a member who is turning 21 years of age.

   c. Chapter 1600, Policy 1620, Exhibit 1620-9, is used by ALTCS Contractors.

2. Relinquishing Contractors who fail to notify the receiving Contractors of transitioning members with special circumstances, or fail to send the completed ETI form, will be responsible for covering the member's care resulting from the lack of notification, up to 30 days.

   NOTE: CRS will notify the AHCCCS Contractor in writing 60 days prior to the member's 21st birthday to ensure continuity of care. CRS is not financially responsible for an AHCCCS member on or after his/her 21st birthday.

3. Contractors must also provide protocols for the transfer of pertinent medical records, as discussed in this policy, and the timely notification of members, subcontractors or other providers, as appropriate during times of transition.

4. Receiving Contractors must provide new members with their handbook and emergency numbers within ten days of transition for acute care members and 12 days of transition for ALTCS members (allows for case management on-site visit).

5. Receiving Contractors must follow up as appropriate on the needs identified on the ETI.

AHCCCS TRANSITION POLICIES

AHCCCS has specific policies for member transition issues including, but not limited to:

1. Transition to an ALTCS Contractor from an acute care Contractor
2. Transition to an acute care Contractor from an ALTCS Contractor
3. County to county transitions
4. Transition to an acute care or ALTCS Contractor by a CRS member who is turning 21 years of age
5. Transition of members hospitalized during an enrollment change
6. Transition during major organ and tissue transplantation services
7. Enrollment changes for members receiving outpatient treatment for significant conditions
8. Transfer and interim coverage of prescription medications
9. Disposition of durable medical equipment, orthotics, prosthetics and other medical supplies, and
10. Transfer of medical records

TRANSITION TO ALTCS

If a member is referred to and approved for ALTCS enrollment, the acute care Contractor must coordinate the transition with the assigned ALTCS Contractor to assure that applicable protocols are followed for any special circumstances of the member, and that continuity and quality of care is maintained during and after the transition.

Refer to Chapter 1600, Policy 1620 of this Manual for ALTCS Contractor responsibilities in the transition process.

- **TRANSITION TO ACUTE CARE CONTRACTOR FROM ALTCS CONTRACTOR**

  If a member is determined through Pre-Admission Screening (PAS) reassessment to no longer need long term care through ALTCS or the ALTCS-Transitional program, and the member is determined eligible for acute care enrollment, he/she will be transitioned to an acute care Contractor. The ALTCS Contractor receives a prior plan list for members that are being disenrolled. The ALTCS Contractor uses this list to identify members needing an ETI completed and forwards it and any other appropriate information to the acute care Contractor. The member's ALTCS case manager must be involved in the transition process in order to assure that continuity and quality of care for the member is maintained. Acute care Contractors must implement protocols for the special circumstances that ALTCS transitioning members may experience.

  The protocols must include a comprehensive evaluation to determine the treatment and service regimen. The ALTCS treatment and service regimen received by the member must be maintained by the acute care Contractor until that determination is made. The exception is for ALTCS services that are not covered by acute care Contractors (e.g., attendant care or home delivered meals, etc.). The evaluation must encompass each service the member is currently receiving through the ALTCS Contractor.

  Using information gathered from the comprehensive evaluation, the PAS, the care plan, medical history, and information obtained from the ALTCS case manager, the acute care Contractor must develop an individualized treatment plan based on the member's needs, past progress and projected outcomes.

- **COUNTY TO COUNTY TRANSITIONS**

  1. Acute care Contractors are responsible for coverage of emergency services for members included on their member roster on the date the service was provided. This applies to members who have moved out of the acute care Contractor service area.

2. ALTCS Contractors may remain responsible for all services dependent upon whether the member is institutionalized or receiving home and community based services even though the ALTCS member moves out of their service area (but not out of the State).

3. If a Contractor has service areas in multiple counties of the State and a member moves to a new service area that the Contractor serves, the member will remain enrolled with that Contractor. The member must report the change in address to the member's eligibility determination agency for reevaluation of the member's eligibility. It is the responsibility of the Contractor to inform the member in writing of his/her obligation in this regard.

   The eligibility agency will send the address change to AHCCCS and the AHCCCS member file will be automatically updated with the correct address and enrollment locator code. There may be a different capitation rate in the new service area for that Contractor.

4. Contractors are responsible for the facilitation of enrollment transfers and ensuring that services for members are not interrupted.

- **TRANSITION TO AN ACUTE CARE/ALTCS CONTRACTOR BY A CRS MEMBER WHO IS TURNING 21 YEARS OF AGE**

AHCCCS special needs members who are under the care of CRS must be transitioned to an acute care/ALTCS Contractor on their 21st birthday. CRS staff will:

1. Submit the CRS ETI form (Exhibit 520-2) to the receiving (acute care or ALTCS) Contractor Transition Coordinator 60 days prior to the member's 21st birthday

2. Include medical records as appropriate

3. Coordinate with the receiving AHCCCS Contractor utilization management staff, hospital staff and PCP when the member is in the hospital on his/her 21st birthday, and

4. As a relinquishing Contractor, be accountable, as applicable, for all other timeframes and processes noted in this policy.

Refer to Chapter 400, Policy 450, for more information regarding CRS.

- **MEMBERS HOSPITALIZED DURING AN ENROLLMENT CHANGE**

1. The Contractor will make provisions for the smooth transition of care for members who are hospitalized on the day of an enrollment change. The provisions must include protocols for the following:

   a. Authorization of treatment by the receiving Contractor on an individualized basis. The receiving Contractor must address contracting for continued treatment with the institution on a negotiated fee basis, as appropriate.

   b. Notification to the hospital and attending physician of the transition by the relinquishing Contractor. The relinquishing Contractor must notify the hospital and attending physician of the pending transition prior to the date of the transition and instruct the providers to contact the receiving Contractor for authorization of continued services. If the relinquishing Contractor fails to provide notification to the hospital and the attending physician relative to the transitioning member, the relinquishing Contractor will be responsible for coverage of services rendered to the hospitalized member for up to 30 days. This includes, but is not limited to, elective surgeries for which the relinquishing Contractor issued prior authorization.

   c. Coordination with providers regarding activities relevant to concurrent review and discharge planning must be addressed by the receiving Contractor, along with the mechanism for notification regarding pending discharge.

   d. Transfer of care to a physician and/or hospital affiliated with the receiving Contractor. Transfers from an out-of-network provider to one of the receiving Contractor providers cannot be made if harmful to the member's health and must be determined medically appropriate. The transfer may not be initiated without approval from the relinquishing Contractor primary care provider, or the receiving Contractor Medical Director.

Note: Members in Critical Care Units, Intensive Care Units and Neonatal Intensive Care Units require close consultation between the attending physician and the receiving Contractor physician. If a member is admitted to an inpatient facility while still assigned to the relinquishing Contractor, and discharged after transition to the receiving Contractor, both must work together to coordinate discharge activities.

2. The relinquishing Contractor will be responsible for coordination with the receiving Contractor regarding each specific prior authorized service. For members known to be transitioning, the relinquishing Contractor will not authorize hospital services such as elective surgeries scheduled less than 15 days prior to enrollment with the receiving-Contractor. If authorized to be provided during this time frame, the service for the transitioning member will be the financial responsibility of the Contractor, who authorized the service.

NOTE: CRS will notify the AHCCCS Contractor in writing 60 days prior to the member's 21st birthday to ensure coordination of care. CRS is not financially responsible for an AHCCCS member on or after his/her 21st birthday.

- **TRANSITION DURING MAJOR ORGAN AND TISSUE TRANSPLANTATION SERVICES**

1. If there is a change in Contractor enrollment, both the relinquishing and receiving Contractors will be responsible for coordination of care and coverage for members awaiting major organ or tissue transplantation from the time of transplantation evaluation and determination through follow-up care after the transplantation surgery. If a member changes Contractor enrollment whole undergoing transplantation at an AHCCCS-contracted transplant center, the relinquishing Contractor is responsible for contracted components or modules of the service up to and including completion of the service modules that the member is receiving at the time of the change. The receiving Contractor is responsible for the remainder of the module components of the transplantation service.

2. If a member changes to a different Contractor while undergoing transplantation at a transplant center that is not an AHCCCS-contracted provider, each Contractor is responsible for its respective dates of service. If the relinquishing Contractor has negotiated a special rate, it is the responsibility of the accepting Contractor to coordinate the continuation of the special rate with the respective transplant center.

- **ENROLLMENT CHANGES FOR MEMBERS RECEIVING OUTPATIENT TREATMENT FOR SIGNIFICANT MEDICAL CONDITIONS**

1. Contractors must have protocols for ongoing care of active and/or chronic "high risk" (e.g., outpatient chemotherapy, home dialysis, etc.) members and pregnant members during the transition period. The receiving Contractor must have protocols to address the timely transition of the member from the relinquishing primary care provider (PCP) to the receiving PCP, in order to maintain continuity of care.

2. The receiving Contractor must address methods to continue the member's care, possibly through contracting on a negotiated rate basis with the member's current provider(s) and/or assisting members and providing instructions regarding their transfer to providers affiliated with the receiving Contractor.

3. Receiving Contractors are also responsible for coordination of the transition of pregnant women to maintain continuity of care. Pregnant women who transition to a new Contractor within the last trimester of their expected date of delivery must be allowed the option of continuing to receive services from their established physician and anticipated delivery site.

- **TRANSITION OF MEDICALLY NECESSARY TRANSPORTATION**

Service delivery locations may necessitate changes in transportation patterns for the transitioning member. Contractors must have protocols for at least the following:

1. Information to new members on what, and how, medically necessary transportation can be obtained

2. Information to providers on how to order medically necessary transportation.

Refer to Chapter 300 for complete information regarding transportation service coverage.

Refer to Chapter 800 for complete information regarding FFS transportation coverage.

- **TRANSITION OF PRESCRIPTION MEDICATION SERVICES**

Contractors must address the issues of dispensing and refilling prescription medications during the transition period, and develop protocols for at least the following:

1. Relinquishing Contractors must cover the dispensing of the total prescription amount of either continuing or time-limited medications, if filled before midnight on the last day of enrollment. In addition, the relinquishing Contractor must make provisions to provide sufficient continuing medications for up to 15 days subsequent to the transition date.

2. Receiving Contractors must address prior authorization of prescription medication and refills of maintenance medication within 14 days of the member's transition.

3. The relinquishing Contractor must provide notice to the receiving Contractor primary care provider of transitioning members who are currently taking prescription medications for medical conditions requiring ongoing use of medication, such as, but not limited to, immunosuppressant, psychotropic and cardiovascular medications, or unusually high cost medications.

NOTE: CRS will notify the AHCCCS Contractor in writing 60 days prior to the member's 21st birthday to ensure coordination of care. CRS is not financially responsible for a member's medications on or after his/her 21st birthday.

Refer to Chapter 300 for complete information regarding prescription medication coverage.

- **DISPOSITION OF DURABLE MEDICAL EQUIPMENT, ORTHOTICS, PROSTHETICS AND OTHER MEDICAL SUPPLIES DURING TRANSITION**

Contractors must address the disposition of durable medical equipment (DME) and other medical equipment during a member's transition period and develop protocols that include the following:

1. Non-customized DME

   a. The relinquishing Contractor must provide transitioning members with DME for up to 15 days after the transition date or until the receiving Contractor supplies the service. The receiving Contractor must supply necessary DME within 14 days following the transition date.

   b. To facilitate continuity of services, the receiving Contractor is encouraged to:

      (1) Negotiate and/or contract for continued services with the member's current provider, and/or

      (2) Provide instructions and assistance to new members on how to transfer to a DME provider who belongs to the new Contractor network.

   c. The receiving Contractor must assess medical necessity of DME if equipment was rented by the relinquishing Contractor.

2. Customized DME:

   For purposes of this policy, customized DME is defined as equipment that has been altered or built to specifications unique to a member's medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.

   a. Customized DME purchased for members by the relinquishing Contractor will remain with the member after the transition. The cost of the equipment is the responsibility of the relinquishing Contractor.

b. Customized DME ordered by the relinquishing Contractor but delivered after the transition to the receiving Contractor will be the financial responsibility of the relinquishing Contractor.

c. Maintenance contracts for customized DME purchased for members by a relinquishing Contractor will transfer with the member to the new Contractor. Contract payments due after the transition will be the responsibility of the receiving Contractor, if they elect to continue the maintenance contract.

3. Augmentative Communication Devices (ACDs)

A 90 day trial period is generally necessary to determine if the ACD will be effective for the member, or if it should be replaced with another device.

If a member transitions from one Contractor to another during the 90 day trial period, one of the following will occur:

a. If the ACD is proven to be effective, the device remains with the member. Payment for the device is the responsibility of the relinquishing Contractor. The cost of any maintenance contract necessary for the ACD becomes the responsibility of the receiving Contractor, if they elect to continue the maintenance contract, OR

b. If the ACD is proven to be ineffective, it is returned to the relinquishing Contractor. The receiving Contractor must reassess the member's medical condition and purchase a new device if it is determined to be potentially effective in meeting the member's needs.

NOTE: If the member has had the ACD for more than 90 day trial period, the customized DME process in section 2 applies.

Refer to Chapter 300 for additional information regarding DME.

- **MEDICAL RECORDS TRANSFER DURING TRANSITION**

Medical records must be forwarded when there is significant consequence to current treatment, or if requested by the receiving primary care provider (PCP) or specialty provider. The cost of copying and transmitting of the medical record information specified in this policy will be the responsibility of the relinquishing PCP unless otherwise noted.

To ensure continuity of member care during the time of enrollment change, Contractors must have the following procedures in place to ensure timely medical records transfer:

1. Procedure to be used by the relinquishing Contractor PCP to transfer member records to the receiving Contractor PCP.

2. Procedure regarding:

   a. The portions of a medical record to copy and forward to the receiving Contractor PCP. The relinquishing PCP must transmit at least those records related to diagnostic tests and determinations, current treatment services, immunizations, hospitalizations with concurrent review data and discharge summaries, medications, current specialist services, behavioral health quarterly summaries and emergency care.

   b. A timeframe definition for the receipt of medical records by the receiving PCP (i.e., on the date of transfer, after hospital discharge, prior to transfer).

3. Procedure for maintaining confidentiality of each member's medical records. In accordance with Federal or State laws and Court orders, Contractors must comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements and 42 CFR 431.300 *et seq*.

4. Procedure for the transfer of other requested medical records, which exceeds the requirements of this policy, including resolution of the question of payment for copying and transmitting medical record data.

Refer to Policy 550 of this chapter, Chapter 600 and Chapter 900 for additional AHCCCS requirements related to medical records and confidentiality.

EXHIBIT 520-1

ACUTE CARE
ENROLLMENT TRANSITION INFORMATION FORM

EXHIBIT 520-1
ACUTE CARE ENROLLMENT TRANSITION INFORMATION FORM

1	Member Name	AKA	Telephone	
2	AHCCCS ID #	DOB	Male Female	
3	Rate Code	County Name & #		
4	Receiving Contractor			
5	Medicare Part A Part B	Other Insurance	Plan #	
6	ALTCS Application Pending Yes No	Date	Branch	

7	Diagnosis	Secondary Diagnosis	
8	PCP Name	PCP Telephone	
9	Pregnancy EDC	Maternity Care Provider	Telephone
10	High Risk Yes No	Explain Risk	
11	Special Medication		

12	Specialist Name	Type	Telephone
13	Specialist Name	Type	Telephone
14	Out-of-Area-Appointment Yes No	Provider	Telephone
15	Outpatient Services	Provider	Telephone
16	Outpatient Services	Provider	Telephone
17	Home Health Yes No	Provider	Telephone
18	Home Health Services		
19	Case Management Yes No	Please Explain	

20	Inpatient Yes No Hospital SNF	Facility Name	Telephone	
21	Admitting Diagnosis			
22	Inpatient Treatments			
23	Admission Date	Expected Discharge Date		

24	CRS Diagnosis(s)
25	CRS Clinic(s)

26	Behavioral Health Yes No	RBHA 18-20	Provider	Telephone

27	DME Vendor	
28	Type of DME Equipment	Own Rent
29	Requiring Supplies Yes No	Type

30	Ongoing Medical Transportation Yes No	Mode
31	Date Transportation Needed	Destination

32	Person Completing Form	Telephone
33	Date of Notification to Receiving Contractor	
34	Behavioral Health or Nursing Facility Services since 10-1	Behavioral Health / Nursing Facility

This information is considered CONFIDENTIAL and disclosure is governed by applicable Federal, State, and Agency regulations. Information on this form is current as of this notification date. This form must be completed for all members requiring transition services in accordance with AHCCCS policies: No changes or revisions to this form are permitted without written approval from AHCCCSA. Rev 4/2005, 4/98.

EXHIBIT 520-2

CHILDREN'S REHABILITATIVE SERVICES ENROLLMENT TRANSITION INFORMATION FORM (TO BE USED BY CRS STAFF ONLY)

EXHIBIT 520-2

CRS ENROLLMENT TRANSITION INFORMATION FORM - PAGE 1 OF 2

CRS SITE	PHOENIX ☐ ST. JOSEPH ☐ BANNER DESERT ☐ PHOENIX CHILDRENS ☐	FLAGSTAFF ☐	YUMA ☐	TUCSON ☐ TUCSON MEDICAL ☐ UNIVERSITY MEDICAL ☐

Member Name	**AKA**	**Phone**
Member Address		
AHCCCS ID # **Medical Record #**	**DOB**	**Male** ☐ **Female** ☐
Legal Guardian Name		**Phone**
Address		
Receiving AHCCCS Contractor		
Medicare Part A ☐ **Part B** ☐ **Yes** ☐ **No** ☐ **Unknown** ☐	**Other Insurance Carrier**	**Plan #**
ALTCS / DD Application Pending **Yes** ☐ **No** ☐	**Date**	**Branch**
Diagnosis	**Secondary Diagnosis**	
CRS Diagnoses		
1.	**3.**	
2.	**4.**	
PCP Name		**PCP Phone**
Medical High Risk **Yes** ☐ **No** ☐	**Explain Risk**	
Case Management Referral? **Yes** ☐ **No** ☐	**Explain Risk**	
Special Medication (dosage / quantity)		

SPECIALIST INFORMATION		
Specialist Name **Provide Adult Care (over 21): Yes** ☐ **No** ☐	**Type**	**Phone**
Specialist Name **Provide Adult Care (over 21): Yes** ☐ **No** ☐	**Type**	**Phone**
Specialist Name **Provide Adult Care (over 21): Yes** ☐ **No** ☐	**Type**	**Phone**
Specialist Name **Provide Adult Care (over 21): Yes** ☐ **No** ☐	**Type**	**Phone**
Specialist Name **Provide Adult Care (over 21): Yes** ☐ **No** ☐	**Type**	**Phone**

EXHIBIT 520-2
CRS ENROLLMENT TRANSITION INFORMATION FORM – PAGE 2 OF 2

Specialist Name **Provide Adult Care (over 21): Yes ☐ No ☐**	**Type**	**Phone**
Out-of-State-Appointment **Yes ☐ No ☐**	**Provider**	**Phone**
Future Appointments Yes ☐ No ☐ **Date: _____**	**Provider**	**Phone**
Future Appointments Yes ☐ No ☐ **Date: _____**	**Provider**	**Phone**
Future Appointments Yes ☐ No ☐ **Date: _____**	**Provider**	**Phone**
Ancillary Services **Willing to follow Yes ☐ No ☐**	**Provider**	**Phone**
Ancillary Services **Willing to follow Yes ☐ No ☐**	**Provider**	**Phone**
Home Health Yes ☐ No ☐	**Provider**	**Phone**
Home Health Services		
Hospital	**Facility Name**	**Phone**
DME Vendor (orthotic, prosthesis)		**Own ☐ Rent ☐**
DME Vendor (w/c)		**Own ☐ Rent ☐**
DME Vendor (other)		**Own ☐ Rent ☐**
Requiring Supplies Yes ☐ No ☐	**Type**	
Date of Notification to Receiving Contractor		
Behavioral Health Yes ☐ No ☐	**Medical Records Attached? Yes ☐ No ☐**	

Additional Comments:

_____

_____

_____

Contact Person: _____Telephone Number: _____

Initial Eff. Date: 4/1/2005

530 MEMBER TRANSFERS BETWEEN FACILITIES

- **TRANSFERS FOLLOWING EMERGENCY HOSPITALIZATION**

1. Transfers initiated by the Contractor between inpatient hospital facilities may be made when the following conditions are present:

   a. The attending emergency physician, or the provider actually treating the member, determines that the member is sufficiently stabilized for transfer and will remain stable for the period of time required for the distance to be traveled

   b. The receiving physician agrees to the member transfer

   c. The member is expected to remain stable, considering the period of time required for the distance to be transferred

   d. Transportation orders are prepared which specify the type of transport, training level of the transport crew and level of life support, and

   e. A transfer summary accompanies the member.

2. Transfer to a facility lesser level of care may be made when one or more of the following criteria are met:

   a. Member's condition does not require full acute hospital capabilities for diagnostic and/or treatment procedures

   b. Member's condition has stabilized or reached a plateau and will not benefit further from intensive intervention in an acute care hospital.

3. The attending emergency physician or the provider actually treating the member and the Contractor Medical Director or designee are responsible for determining whether a particular case meets criteria established in policy. In the event of a request for a decision by AHCCCS on the transfer of a particular member, AHCCCS will apply the criteria listed in this subsection and Arizona Revised Statute 36-2909(B).

- **NEONATE TRANSFERS BETWEEN ACUTE CARE CENTERS**

Acutely ill neonates mat be transferred from one acute care center to another, given certain conditions. The chart that follows provides the levels of care, conditions appropriate for transfer, and criteria for transfer.

LEVEL OF CARE FROM	TO	TRANSFER CRITERIA
Primary	**Secondary**	1. The nursing and medical staff of the sending hospital cannot provide: a. The level of care needed to manage the infant beyond stabilization to transport, or b. The required diagnostic evaluation and consultation services needed. 2. Transport orders are prepared which specify the type of transport, the training level of the transport crew and the level of life support. 3. A transfer summary accompanies the infant.
	Tertiary	Same as above
Secondary	**Tertiary**	Same as above
	Primary	Same as below
Tertiary	**Tertiary (Rare)**	1. The sending and receiving neonatalogists (and surgeons, if involved) have spoken and have agreed that the transfer is safe 2. The infant is expected to remain stable, considering the period of time required for the distance to be covered. 3. Transport orders are prepared which specify the type of transport, training level of the transport crew, and 4. A transfer summary accompanies the infant.
	Secondary	Same as above
	Primary	Same as above

540 OTHER CARE COORDINATION ISSUES

Other care coordination issues which require policies include, but are not limited to:

1. Member problem resolution
2. Members presenting for care outside the Contractor's provider network, and
3. Members with special health care needs.

- **MEMBER PROBLEM RESOLUTION**

AHCCCS will provide available and accessible member service representatives to resolve problems in a timely manner for those members not enrolled with a Contractor.

Refer to Chapter 900 (Policy 960) and AHCCCS Contracts for managed care member problem resolution.

- **MEMBERS PRESENTING FOR CARE OUTSIDE THE CONTRACTOR'S PROVIDER NETWORK**

Contractors must establish procedures for assisting members when they present to a non-contracted provider. This procedure should include, but is not limited to:

1. Specific Contractor contact person for assistance
2. Telephone number to obtain Contractor information, and
3. Map or addresses of service locations.

- **MEMBERS WITH SPECIAL HEALTH CARE NEEDS**

Definition. Members with special health care needs are those members who have serious and chronic physical, developmental or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally. A member will be considered as having special health care needs who has a medical condition that simultaneously meets the following criteria:

1. Lasts or is expected to last one year or longer, and

2. Requires ongoing care not generally provided by a primary care provider.

AHCCCS has determined that the following populations meet this definition:

1. Acute Care:

    a. Members who are recipients of services provided through the Arizona Department of Health Services Children's Rehabilitative Services program

    b. Members who are recipients of services provided through the Arizona Department of Health Services/Division of Behavioral Health-contracted Regional Behavioral Health Authorities, and

    c. Members diagnosed with HIV/AIDS.

2. Arizona Long Term Care System (ALTCS):

    a. Members enrolled in the ALTCS program who are elderly or physically disabled, and

    b. Members enrolled in the ALTCS program who are developmentally disabled.

Contractors may choose to identify as members with special health care needs any other members who they determine meet the definition. If a Contractor designates additional members or groups of members as meeting the definition, the Contractor shall be required to identify those members and the services they receive for purposes of any State or Federal reporting requirements.

Contractor Requirements. Contractors must implement mechanisms to assess each member identified as having special health care needs, in order to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. The assessment mechanism must use appropriate health care professionals.

The contractor shall share with other entities providing services to that member the results of its identification and assessment of that member's needs.

For members with special health care needs determined to need a specialized course of treatment or regular care monitoring, the Contractor must have procedures in place to allow members to directly access a specialist (e.g., through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

550 MEMBER RECORDS AND CONFIDENTIALITY

All AHCCCS providers and Contractors must protect member information in accordance with Federal and State laws, Rules, AHCCCS policies and AHCCCS contracts.

Consistent with 9 A..A.C. 22, Article 5, AHCCCS, Contractors, providers and non-contracted providers must safeguard the privacy of records and information about members who request or receive services from AHCCCS or its Contractors.

Information from, or copies of, medical records may be released only to authorized individuals, and processes must be in place to ensure that unauthorized individuals cannot gain access to, or alter, medical records.

Original and/or copies of medical records must be released only in accordance with Federal or State laws or Court orders. Contractors and providers must comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements and 42 CFR 431.300 *et seq*.

Refer to Chapter 900 (Policy 940) for a complete discussion of member records and member information for Contractors.

Refer to Chapter 600 (Policy 650) for more information regarding release of information.

Refer to Chapter 700 for member medical record information regarding members who receive Medicaid direct services through their school system.

560 EMERGENCY SERVICES FOR MEMBERS ENROLLED WITH CONTRACTORS

Policy 560 is limited to members enrolled with managed care Contractors. It does not apply to the Federal Emergency Services Program members (Chapter 1100) or the Fee for Service program members (Chapter 800).

For purposes of Policy 560, the term "provider" means hospitals, emergency department providers or fiscal agents.

Description. AHCCCS covers emergency medical services provided by qualified medical and nursing personnel for all members enrolled with Contractors, as specified in 42 CFR 438.114. Emergency medical services are those services needed to evaluate or stabilize an emergency medical condition. An emergency medical condition is treatment for a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the member's health in serious jeopardy

2. Serious impairment of bodily functions, or

3. Serious dysfunction of any bodily organ or part.

Amount, Duration and Scope.

Contractors are responsible for:

1. Providing all emergency medical services to enrolled members

2. Developing guidelines for member education to ensure the appropriate utilization of emergency room services, and they are encouraged to employ the services of non-emergency facilities (e.g., urgent care centers) to address member non-emergency care issues occurring after regular office hours or on weekends.

3. Paying the provider for emergency medical services rendered to a member when a Contractor's employee instructs the member to obtain emergency medical services

4. Not denying payment to the provider based on the failure of the provider to notify the Contractor by the 11th day from the day that the member presented for the emergency medical services.

Providers are responsible for notifying the Contractor by the 11th day from presentation for the emergency inpatient medical services. Failure to provide timely notice is cause for denial of payment for the emergency inpatient medical services.

When the emergency condition is stabilized or the member is ready for transfer or discharge, the provider is responsible for compliance with post-stabilization care requirements described in this policy.

- **POST STABILIZATION CARE SERVICES**

Description. Post Stabilization Care Services are covered services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or, under the circumstances described under 42 CFR 438.114(e), to improve or resolve the member's condition. This provision states that post-stabilization services are paid in accordance with 42 CFR 422.113(c)

Amount, Duration and Scope. Under 42 CFR 438.114, and 42 CFR 422.113(c), the following conditions apply with respect to coverage and payment of post-stabilization care services:

When medical post-stabilization services are administered to maintain, improve or resolve the member's stabilized condition, the Contractor must cover and pay for post-stabilization care services without authorization, regardless of whether the provider that furnishes the service has a contract with the Contractor, for the following situations:

1. Post-stabilization care services that were prior authorized by the Contractor

2. Post-stabilization care services that were provided within the first hour of request to maintain the member's stabilized condition

3. Post-stabilization care services were not prior authorized by the Contractor because the Contractor did not respond to the treating provider's request for pre-approval within one hour after being requested to approve such care or could not be contacted for pre-approval.

4. The Contractor representative and the treating physician cannot reach agreement concerning the enrollee's care and a Contractor physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the patient until a Contractor physician is reached or one of the criteria in CFR 422.113(c)(3) is met.

Under CFR 422.113(c)(3), the Contractor's financial responsibility for post-stabilization care services that have not been prior authorized ends when:

1. A Contractor physician with privileges at the treating hospital assumes responsibility for the member's care

2. A Contractor physician assumes responsibility for the member's care through transfer

3. A Contractor representative and the treating physician reach an agreement concerning the member's care, or

4. The member is discharged.